United Behavioral Health

**Coverage Determination Guideline: Dissociative Identity Disorder**

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**INTRODUCTION**

*Coverage Determination Guidelines* are a set of objective and evidence-based behavioral health criteria used by Commercial plans that don’t have a provision for medical necessity to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®¹.

**INSTRUCTIONS FOR USE**

This guideline provides assistance in interpreting UnitedHealthcare Commercial benefit plans, and is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member’s specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

**BENEFIT CONSIDERATIONS**

*Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.*
Available benefits for anxiety disorders include the following services:

- Diagnostic evaluation, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

**Indications for Coverage**

The requested service or procedure must be reviewed against the language in the member’s benefit document. When the requested service or procedure is limited or excluded from the member’s benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines.

**A. Initial evaluation common criteria and best practices**

- Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  - [http://www.psychiatry.org](http://www.psychiatry.org) > Psychiatrists > Practice > Clinical Practice Guidelines

- Dissociative disorders (DDs) are a cluster of disorders that are often associated with a history of psychological trauma (Brand et al., 2016).
- DDs are described as a chronic posttraumatic disorder where adverse events in childhood, including abuse, maltreatment, neglect, disturbed emotional attachments, and poor boundaries are the central features (Sar et al., 2017).
- DDs often feature a disturbance in (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 2013):
  - Identity;
  - Memory;
  - Perception;
  - Consciousness;
  - Motor Control;
  - The disturbance must not be a normal part of a broadly accepted cultural, spiritual, or religious practice experienced in many cultures around the world.

- Subtypes of dissociative disorders include (Loewenstein, 2018):
  - Dissociative identity disorder (DID) - formerly referred to as multiple personality disorder.
  - Dissociative amnesia (DA) – loss of autobiographic memory for previous experiences or before a certain point in time.
  - Dissociative fugue (DF) – has the same characteristics as DA and is now a subtype of DA.
  - Depersonalization/derealization disorder (DPDRD) – also known as derealization disorder in which there is a belief that they have been altered in some way or that they are no longer real.

- Diagnostic tests that are available when administered by a professional include (International Society for the Study of Trauma and Dissociation [ISSTD], 2020):
  - Structured Clinical Interview for Dissociative Disorders (SCID-D)
  - Multidimensional Inventory of Dissociation (MID)
  - Dissociative Disorders Interview Scale (DDIS)

- Self-administered tests are available as self-reported screening measures (Sar et al., 2017):
  - Dissociative Experiences Scale (DES)
  - Dissociation Questionnaire (DISQ)

- According to the ISSTD (2011), dissociative disorders are not rare, there are at least as common as many psychiatric diagnoses that are regularly addressed in psychiatric evaluations; assessment for dissociation should be performed as a part of every diagnostic consultation.

**B. Differential Diagnoses**
Clinicians must be able to recognize and diagnose nondissociative disorders to avoid incorrectly diagnosing DID or failing to identify the presence of true comorbid conditions (Brand et al., 2016).

Accurate clinical diagnosis provides the opportunity for an early and appropriate treatment plan for dissociative disorders (ISSTD, 2011).

Dissociative disorders are thought to develop after experiencing chronic, severe emotional or physical trauma with numerous symptoms that can be overlooked (Brand et al., 2016). A differential diagnosis includes assessing the following (APA, 2013):

- Distinguishing among acute substance intoxication, withdrawal, or substance-induced persisting amnestic disorders;
- Distinguishing from amnesia disorder due to brain injury, seizure disorders, delirium, dementia, age related cognitive decline and nonpathologic forms of amnesia (such as amnesia for sleep and memory loss);
- Identifying symptoms due to physiologic consequences of a medical condition;
- Depersonalization/derealization disorder should not be diagnosed when symptoms occur during a panic attack or in the context of panic disorder, phobias or stress disorders;
- Major depressive disorder;
- Bipolar disorders;
- Conversion disorder;
- Psychotic disorders.

Due to the complexity of DID as a posttraumatic disorder, borderline personality disorder also shares similar clinical features and must be diagnosed accurately (Foote & Orden, 2016).

C. Treatment planning and best practices
   - Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
     - [http://www.psychiatry.org](http://www.psychiatry.org) > Psychiatrists > Practice > Clinical Practice Guidelines
   - Treatment should progress the individual toward better integrated functioning whenever possible (ISSTD, 2011).
   - Helping an individual’s identities be aware of one another as legitimate parts of the self and to negotiate and resolve their conflicts is the foundation of the therapeutic process (ISSTD, 2011).
   - A desirable outcome for treatment is a workable form of integration or harmony among an individual's alternate identities (ISSTD, 2011).

D. Psychotropic medication is not a primary treatment for dissociative processes, and further research is necessary regarding specific recommendations for pharmacotherapy for most symptoms (ISSTD, 2011);
   - FDA approved medications such as anxiolytics, antidepressants or antipsychotics may be considered to treat co-occurring mood and anxiety symptoms (ISSTD, 2011).

E. The primary treatment modality for DID is individual outpatient psychotherapy, such as cognitive behavioral therapy (ISSTD, 2011).
   - The ISSTD (2011) recommends individual psychotherapy treatment in three sequenced stages:
     - First stage: focused on safety and establishing a therapeutic alliance.
     - Second stage: the focus is on processing, confronting, and reconcile trauma.
     - Third stage: the final stage is focused on integrating self and rehabilitation.
   - Individuals with DID do not function well in generic therapy groups; group psychotherapy is not considered a worthwhile treatment plan (ISSTD, 2011).
   - Eye movement desensitization and reprocessing (EMDR) can be helpful when used within an overall treatment approach, rather than as a standalone treatment (ISSTD, 2011).
     - EMDR is recommended only when the patient is generally stable, has adequate coping skills, internal cooperation among alternate identities, and an ability to maintain a dual focus of awareness (ISSTD, 2011).
     - Certain time-limited groups for selected patients can be valuable adjuncts to individual psychotherapy (ISSTD, 2011).
   - Individuals with DID may benefit from incorporating dialectical behavior therapy (DBT) with other psychotherapy approaches (ISSTD, 2011).
According to Foote & Orden (2016), DBT may be effective in some individuals because it is a staged or sequenced treatment in which safety is addressed in the first phase and trauma processing in the second phase.

REFERENCES


REVISION HISTORY

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<td>10/11/2016</td>
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<td>10/11/2017</td>
<td>Version 2 – Annual Update</td>
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<td>01/27/2020</td>
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<tr>
<td>10/19/2020</td>
<td>Removal of coding grids</td>
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